INDIVIDUALIZED FAMILY SERVICE PLAN (IFSP)

The Individualized Family Service Plan describes
how the First Steps early intervention system will assist each family in helping
their very young child with a disability or developmental delay to grow and develop.

Missouri First steps EARLY INTERVENTION

Section 1: CHILD INFORMATION

*Child's Name:_____*Nickname: _____*Gender: M F A

*Home Street/Address: _____*Mailing Address: _____

*City/Town: _____MO, Zip: _____ *County: _____

*Date of Birth: _____ Chronological Age: _____Adjusted Age: _____

*Reason for Eligibility: _____*Native Language : _____

*School District:_____*SSN#: _____ *Medicaid #: _____

DIRECTIONS TO CHILD'S HOME

***MEETING DATE INFORMATION:**

IFSP Meeting Type:

☐ Interim ☐ Initial ☐ 6 Month Review ☐ Interperiodic Review ☐ Annual ☐ Transition

Meeting Date: ____/ ____/ ____

IFSP Start Date: _____/_____/_____ IFSP End Date: _____/_____/____

Child's Name: _____ Date: _____

Section 2: FAMILY INFORMATION

*Primary Contact: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____

*Home/Street Address: _____

*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____
Other way to contact: _____
*Native language:_____
*Interpreter Needed? Yes No

OTHER CONTACT INFORMATION:
*Name: _____

*Relationship to child: _____

*Mailing Address: _____

*City/Town: _____*State: _____*Zip: _____
*Home/Street Address:_____
*Day Phone: _____ (h___ w___)
*Evening Phone: _____ (h___ w___)
*Best time to call: _____
E-mail: _____

Section 3. SERVICE COORDINATOR CONTACT INFORMATION

*Name: _____

*Agency: _____

*Work Telephone: _____

*Cell Phone: _____

*Best time to call: _____

*FAX: _____

*E-mail address: _____

Mailing Address: _____

City/Town: _____

*State: _____ *Zip: _____

*MC+/Plan Contact Person : _____

*Telephone:_____ *FAX Number: _____

*Physician: _____

*Address: _____

*City/Town: _____, State: _____ Zip: _____

Telephone: _____ FAX:_____

E-mail: _____

Child's Name: _____ Date: _____

Section 4: CHILD'S PRESENT ABILITIES AND STRENGTHS: TEAM SUMMARY.

WHAT MY CHILD CAN DO NOW - INTERESTS, MOTIVATORS, NEW SKILLS, THINGS TO CELEBRATE, WHAT MY CHILD IS READY TO DO, WHAT'S WORKING WELL. Make sure that all developmental domains are included. Describe in an integrated, functional manner how this child: does things for him/herself (Adaptive/Self Help Skills); how s/he problem solves and plays (Cognition); how s/he uses hands, oral motor skills, how s/he moves around (Physical Skills); how s/he indicates understanding, wants, and needs (Communication Skills); and how s/he shows feelings, copes with frustration or stimulation, and gets along with others (Social/Emotional Skills).

Adaptive Self Help:

Cognition:

Physical:

Communication:

Social/Emotional:

Vision / Hearing:

Health/Physical/Nutrition Status:

Other Strengths/Concerns including relevant information (medical diagnosis, birth history, health status, sensory issues, etc.) or other concerns, which might affect service delivery.

Child's Name: _____ Date: _____

Section 5. SUMMARY OF FAMILY CONCERNS, PRIORITIES AND RESOURCES TO ENHANCE THE DEVELOPMENT OF THEIR CHILD

Family declined consent to complete an assessment of family concerns, priorities and resources: Yes No (If "yes" leave this section blank, If "no" this section must be completed.)

I have questions about or want help for my child in the following areas:

- ☐ Moving around (crawling, scooting, rolling, walking)
- ☐ Ability to maintain positions for play
- ☐ Talking and listening
- ☐ Thinking, learning, playing with toys
- ☐ Feeding, eating, nutrition
- ☐ Having fun with other children; getting along
- ☐ Behaviors and feelings
- ☐ Toileting; getting dressed; bedtime; other daily routines
- ☐ Helping my child calm down, quiet down
- ☐ Pain or discomfort
- ☐ Special health care needs
- ☐ Seeing or hearing
- ☐ Other: _____

I would like to share the following concerns and priorities for myself, other family members, or my child:

- ☐ Finding or working with doctors or other specialists
- ☐ How different services work or how they could work better for my family
- ☐ Planning for the future; what to expect
- ☐ Parenting skills
- ☐ People who can help me at home or care for my child so I/we can have a break; respite or child care
- ☐ Housing, clothing, jobs, food, or telephone
- ☐ Information on my child's special needs, and what it means
- ☐ Ideas for brothers, sisters, friends, extended family
- ☐ Money for extra costs of my child's special needs
- ☐ Linking with a parent network to meet other families or share information
- ☐ Other: _____

FAMILY'S CONCERNS ABOUT THEIR CHILD

PRIORITIES OF THE FAMILY (Select from items checked to the left)

STRENGTHS, RESOURCES THAT OUR FAMILY HAS TO MEET OUR CHILD'S NEEDS

Child's Name: _____ Date: _____

Section 6. FAMILY AND CHILD CENTERED OUTCOME(S) **This page should be duplicated as needed**

Outcome # _____:

Optional: Strategies and Activities: (Summarize ideas for addressing the outcome within the child and family's naturally occurring routines and environments using people and materials that are available there. This is not a listing of early intervention services)

When will we as a team measure progress towards this outcome? (timeline)

How will we, as a team, measure progress towards this outcome? (procedure)

Our team will be satisfied we are finished with this outcome when: (criteria)

Child's Name: _____ Date: _____

Section 7. *EARLY INTERVENTION RESOURCES, SUPPORTS AND SERVICES This entire page is part of electronic record.

Column A	Col. B	Column C	Column D	Col. E	Col. F	Col. G	Col. H	Col. I	Col. J	Col. K	Col. L
Outcome(s) #	Early Intervention Service(s)	Start Date	End Date	Provider(s) Name	Method (see below)	Ind. Or Group	Location (see below)	Frequency	Intensity	Funding Source	Initial (I) Addition (A) Revision (R)
#											
#											
#											
#											

1) Column F, Method Code: 1 = Consultation/Facilitation with Others; 2 = Family Education/Training/Support; 3 = Direct Child Service
2) Column H, Location Code: 1 = Home; 2 = Other Family Location; 3 = Community Setting; 4 = Special Purpose Center or Clinic

Primary Setting for this IFSP: (circle) special purpose facility - community setting - home - hospital - residential facility - service provider location - other setting

Child's Name_____ Date:_____

***Section 7a. Assistive Technology Authorization – IFSP Meeting Date:_____**

IFSP Outcome #	Start Date	End Date	Provider	HCPCS Code	Description of Item	• Purchase • Rental • Repair	Quantity	Price	Remarks (Optional)

***Section 7b. Transportation Authorization**

IFSP Outcome #	Start Date	End Date	Provider	Frequency	Maximum miles per trip

Child's Name: _____ Date: _____

Section 8: Natural Environments Justification

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Outcome #_____ Service(s)_____ Environment in which service will be provided_____

Explain why the IFSP team determined that it was not appropriate to provide this service in a Natural Environment:

Child's Name _____ Date: _____

Section 9: * Other Services **This entire section is part of the electronic record.**

Service	Family or Child Service	Responsible Individual	Fund Source
	family / child		
	family / child		
	family / child		
	family / child		
	family / child		

Child's Name: _____ Date: _____

Section 10: Transition Checklist

Transition Activities into, within and from First Steps: Identification of activities and responsible individuals to assist the family and child with transitions include:	Specific Transition Issue	Who is responsible
Transition into and within: (Optional)		
1. Transition from hospital, neonatal intensive care unit to home, and into early intervention services to ensure that no disruption occurs in necessary services		
2. Family related changes that may affect IFSP service delivery i.e., employment, birth or adoption of sibling, medical needs of other family members)		
3. Child related changes that may affect IFSP service delivery (i.e., hospitalization or surgery, placement in a child care program, addition of new equipment or technology, medication changes)		
4. Introduction of new or a change in: Service Provider (s) Service location (s)		
5. Termination of existing IFSP service		
6. Explore community program options for our: Child Family		
7. Child and Family exiting First Steps system due to Loss of eligibility Family does not consent to participate		
8. Other Transition		
Comments:		
Transition from (age 2.5 years): 9 & 10 required at each IFSP Meeting		
9. **Discussion** with, and training of parents regarding future placements and other matters related to the child's transition		
10. **Discussion** about procedures to prepare the child for changes in service delivery including steps to help the child adjust and function in a new setting		
11. **Send** with parental consent, information about the child to the local education agency to ensure continuity of services including evaluation and assessment of information and IFSP's		
12. **Send** specified information to community programs, upon informed, written consent, to facilitate service delivery or transition from the First Steps early intervention system		
Comments		

Child's Name:_____ Date:_____

Section 11: IFSP DEVELOPMENT TEAM AND CONTRIBUTORS

Printed Name	Position/Role	Agency (if applicable)	Telephone	Signature or Method of Participation

How will this team keep in touch? How often?

Child's Name _____ Current IFSP Date: _____ Revision Date _____

Section 12: IFSP Review Documentation Worksheet

☐ 6 Month Review ☐ Interperiodic Review

Team Evaluation Scales: 1= Situation changed: outcome not needed, 2= Situation unchanged; still need outcome, 3= Outcome partially attained, 4 = Outcome accomplished

Outcome #	Progress Summary	Team Evaluation	Modifications/Revisions